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BY

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AMPUTATION OF THE CERVIX UTERI.

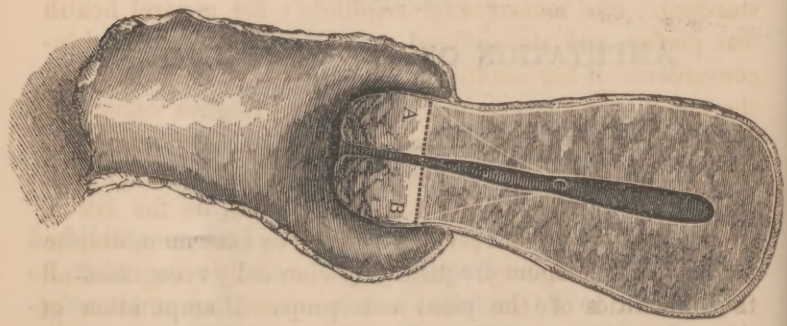
AMPUTATION of the cervix uteri has long been an established operation. Lisfranc frequently performed it for what he considered to be incipient carcinoma. Recent investigations in uterine pathology, however, have demonstrated the fact that his cases were not cancerous, but simply chronic inflammation, with induration and hypertrophy of the cervix. At the present time, Huguier, of Paris, probably performs this operation oftener than any other surgeon. He believes that most displacements of the uterus depend upon chronic enlargement of the cervix, and, laying aside all the local remedies usually employed in such cases, resorts at once to amputation, for which he claims an almost unvarying success.

This operation has been frequently performed by Dr. Emmet and myself, at the Woman's Hospital, sometimes by the knife, at others by scissors, and several times by the ecraseur.

Mrs. W., aged 32, the mother of two children, the youngest three years old, had a constant muco-purulent vaginal discharge and painful menstruation ever since her last confinement. An examination revealed great engorgement and hypertrophy of the cervix, with granular erosion of the os. After having been treated as an out-patient for several months with little improvement, she was admitted to the Woman's Hospital, where she remained for four months without any marked benefit, when it was determined to amputate the cervix. The os was split open laterally nearly to

the insertion of the vagina. The tissue was of almost gristly hardness. Instead of amputating the cervix squarely, as

FIG. I.



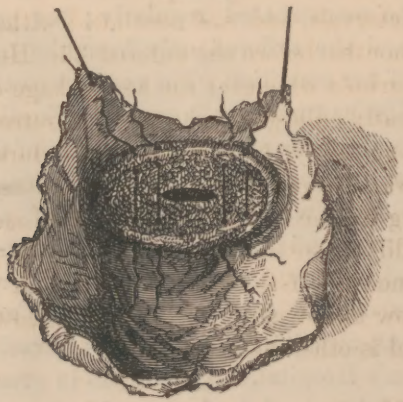
shown by the line A B, Fig. I., the anterior half was first removed, cutting in the direction of the line A C, towards the os internum, after which the posterior half was removed in like manner, cutting in the direction of the line B C, leaving a conical excavation with the apex upwards, this being done to remove as much of the indurated tissue as possible. This mode of operation, however, should not be imitated, for the cicatrization of the wound almost obliterated the cervical canal, which is now very small, notwithstanding repeated incisions and other measures for dilatation. The cervix no longer projects into the vagina; the os is a little round opening, hardly large enough to admit a No. 1 bougie, while, to the touch, the uterus seems to be sitting upon instead of projecting into the vagina.

To guard against the unfortunate result occurring in this case, we adopted the rule of amputating the cervix at two different sittings; thus, splitting it from side to side as before, removing one half, and leaving the parts to cicatrize till the next menstrual period had passed, then removing the other half. We generally followed this plan until the occurrence of an incident in November, 1860, which remodels the whole operation.

Case I.—Mrs. H., from a distant State, 46 years old, a widow for many years, the mother in early life of two children, was the subject of procidentia uteri of fifteen years' standing. She menstruated regularly; her general health was perfect, and she suffered only from the mechanical inconvenience of her condition. The cervix was elongated, and there was a fibrous tumor, as large as an English walnut, in the posterior wall of the uterus. The depth of the organ was three and three-quarter inches. She had worn a Meigs' ring for several months with scarcely any relief, as the cervix protruded through and presented at the os externum, despite all mechanical agency. Her physician fully recognized all the difficulties of the case, and proposed amputation of the cervix; but, unwilling to perform it himself, he sent her to the Woman's Hospital. As she was in great haste to return home, I determined to deviate from our usual course, and to remove the whole cervix at one operation. When she was fully under the influence of ether, Dr. Pratt, the House Physician, informed me that the ecraseur was broken; hence there was no alternative but to employ the cutting process. For this purpose, I used scissors, expecting the hemorrhage to be less than by the knife. I removed about five-eighths of an inch, cutting at right angles, and within half an inch of the vaginal insertion. On beginning the operation, I expected to leave the cut surface to heal by the granulating process, which usually takes five or six weeks; but while sponging the wound, and waiting for the hemorrhage to cease, I discovered that the stump or cut surface could be covered with healthy vaginal tissue in the same manner that the stump of an arm or leg is covered with skin after amputation by the circular method. This was done by passing four sutures of silver wire through the anterior and posterior borders of the wound, (see Fig. II.) which, when

tightly drawn, brought its edges into apposition in a straight line across the middle of the stump, covering it completely,

FIG. II.



but leaving a small central opening for the os, just over the outlet of the cervical canal. (See Fig. III.) The operation

FIG. III.

was followed by no constitutional disturbance. The sutures were removed at the end of a week, the parts having healed entirely by the first intention.

Case II.—Mrs. W., aged 34, entered the Woman's Hospital in January, 1861. She married at nineteen, and

was sterile. She had suffered for eleven years from menorrhagia, accompanied with severe pain in the back and loins, which ceased during a period of six years, then returned at intervals, and had continued without intermission for five months before she entered the Hospital. She also had leucorrhœa whenever the hemorrhage ceased. The uterus was greatly enlarged and somewhat retroverted. The cervix was elongated, hypertrophied and indurated, and the posterior lip was covered with florid vegetations, which bled easily on being touched. I at once proposed amputation, to which she readily assented. The operation was performed in the same manner as before described, and with the same results. She now menstruates regularly, the flow lasting but three days, and is otherwise well.

Case III.—Mrs. R., aged 38, the mother of two children, eighteen and sixteen respectively, for five years a widow, was subject to a leucorrhœa of ten years' standing. She consulted me in February, 1860. She had an enormous enlargement of the cervix uteri, with chronic inflammation and a profuse discharge of an albumino-purulent character. Otherwise, her health was good. She was treated by scarification, potassa cum calce, and other local means, for four months, with some improvement, but it seemed utterly impossible to effect a cure. I saw her in October and November, and again in January, and found her in about the same condition as on her first visit. I then suggested to her the operation of amputation, as being the speediest and best method of cure. It was not convenient for her to submit to it at that time, and the usual course of treatment under such circumstances was adopted. Her improvement was slow and unsatisfactory, and she at length insisted on having the operation performed, which was done, April 29, 1861, in the presence of Dr. Parigot, of Brussels, Dr. Holcomb, of New York, and Dr. Pratt, of the Woman's Hospital. The intra-vaginal portion of the cervix was three-quarters of an inch

in length, and over two inches in diameter. The anterior lip was a little larger than the posterior. The operation was performed as in the preceding cases; namely, by splitting the cervix laterally, and removing, first the anterior, and then the posterior half, by means of scissors. After the hemorrhage had ceased, the vaginal mucous membrane was drawn over the stump, as in the other cases, and secured by four silver sutures, two on each side of the cervical opening. There was no suppuration, no pain, no febrile excitement, and indeed, the patient felt so well that on the next day she wished to get up and go to the parlor; but, for prudential motives, she was confined for a week to her room. Here was a case that had been under treatment, at various times, for fifteen months, with little improvement, cured in a week by this simple operation. The neck of the uterus now presents an appearance so normal that one could hardly believe that it had ever been the subject of disease or of a surgical operation.

In the old method of amputation, the suppuration continued five or six weeks, sometimes longer, before the parts were entirely cicatrized. According to this plan, there is no suppuration, the parts healing by the first intention, and the patient becoming well in a week. In the former, there was danger of pyæmia; in this, there is little, if any. In the former, there was risk of degeneration of tissue; in this, there is none. In the former, the parts contracted as they healed; in this, they remain normal. It might have been supposed, *a priori*, that this operation would have been attended with troublesome hemorrhage, but in each case it ceased as soon as the vaginal tissue was drawn over the stump, and in no instance was a ligature used. In all three of the cases, menstruation has been easy since the operation, although the os was smaller than natural; but, in each case, I enlarged the opening a little by slight incisions.

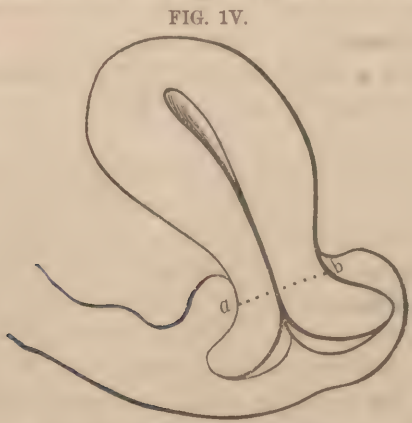
In amputating the tonsils, it is not necessary to cut out the entire gland; the removal of a section will suffice, as a

large part of the remainder will disappear by absorption. In removing an intra-uterine polypus, it is not necessary to cut the pedicle close to the wall of the uterus; if half an inch of it be left, it will disappear by the process of absorption. So in amputating the cervix uteri, it is not necessary to cut it off even with the vaginal insertion to ensure a good result; if half an inch of it be left, it will still decrease by modified nutrition.

Since the publication of the above, in the Transactions of the New York State Medical Society, I have operated upon six additional cases, which I shall relate *seriatim*.

Case I.—Mrs. T., from Illinois, aged 33, married at 22; was the subject of uterine disease, which had existed since the birth of her first and only child, now ten years old. Menstruation was regular, profuse, lasting ten days and attended with severe pain, and she had leucorrhœa of a mucopurulent character. The body of the uterus was enlarged and somewhat anteverted. The cervix was enormously hypertrophied, and the os was lacerated transversely. The cervical mucous membrane was everted, hypertrophied and granulated, and bled easily at the touch. The antero-posterior diameter of the cervix over the os was two and a quarter inches, transversely a little less than two inches, and smaller at the vaginal insertion. (See Fig. IV.) As she had spent five or

FIG. IV.



six years in fruitless efforts to remedy this condition, I suggested amputation. The operation was performed, June 12, 1861, by cutting across the cervix in the direction of the line *a b*, Fig. 4. The stump was covered over with vaginal tissue, secured by five interrupted silver sutures, as before described. The os was kept open by a small plug of

lint, wet with a dilute solution of the per-sulphate of iron. About three-fourths of the cutting was done by scissors, the remainder with the scalpel. The hemorrhage from the first was trifling, from the latter, considerable. About an hour after the operation, a very profuse hemorrhage occurred, which Dr. Emmet controlled with some difficulty by the tampon. As this was the only case out of the nine in which this accident happened, and as it was the only one in which the cutting was not wholly accomplished by scissors, it is presumable that the hemorrhage was due to the use of the knife. She suffered exceedingly from nausea for two days, which was attributed to the chloroform used during the operation; otherwise, she remained very well. The sutures were removed on the eighth day, in the presence of Prof. Valentine Mott, and Prof. Geo. T. Elliot. The parts had united perfectly without any suppuration whatever; menstruation returned within a week afterwards, lasting but four days, and unattended with pain, and thus the patient was cured in a few days of a disease which had existed for years and had been treated for a long time in a neighboring city by eminent surgeons, according to the most approved methods.

Case II.—Mrs. C., aged 25, married four years, sterile, had been subject to dysmenorrhœa ever since marriage. There was anteflexion, with fibrous enlargement of the anterior wall of the uterus. The os was small, the cervix elongated, pointed, and indurated, and the cervical canal contracted. I performed Simpson's operation for dysmenorrhœa, by lateral incisions of the os and cervix, June 18, 1860, which was followed by relief of pain during menstruation; but ever since this operation, she had been subject to vaginitis with pruritus, which seemed to be due to a chronic inflammation of the lining membrane of the lower portion of the cervical canal. After having made fruitless efforts for twelve months to cure this, I determined to amputate the cervix. As it was elongated, I hoped to remove the whole

of the diseased portion that secreted the slight discharge, which evidently produced the vaginitis and pruritus. The cervix was cut squarely off, without splitting the os, the flaps were brought over the cut surface, and secured by silver sutures, as already described, and a small dossil of lint, wet with a dilute solution of per-sulphate of iron, was placed in the central line of union, to keep the os sufficiently open. She suffered very much for two days and nights from nausea and prostration, which were attributed to the chloroform; but there was no febrile excitement, and no pain in the uterine region. The sutures were removed on the eighth day, the parts having healed by the first intention. Since the operation, there has been no vaginitis and no pruritus.

Case III.—Mrs. F., aged 48, had been the subject of procidentia uteri for twenty years. There was an elongation of the cervix. Amputation was performed precisely as in the preceding case, and on the same day. The sutures were removed on the eighth day, in the presence of Dr. Geo. T. Elliot and Dr. Emmet, when the same happy result was found as in the preceding cases. This patient did not suffer from nausea.

Case IV.—Mrs. S. aged 27, married at 20, sterile, had been the subject of menorrhagia for eight years. She had retroversion, with enlargement of the body of the uterus, and great hypertrophy of the cervix, which was so long that the uterus could be placed only in a state of retroversion or of anteversion. The cervix was amputated, June 20, 1861, with the expectation that the menorrhagia would be modified and the hope that the uterus could be made to occupy a normal position without the use of a pessary, which she had worn for the last fifteen months. The operation was performed with the assistance of Drs. Emmet and Pratt, and in the presence of Professors Mott, Elliot and Raphael.

The cervix was amputated squarely with scissors, and without splitting the os. The cut surface was so large that it required six sutures, three on each side of the cervical opening, to bring the vaginal flaps into perfect coaptation. The central opening of the os was dressed as in the preceding cases. She suffered exceedingly from nausea and vomiting for the first twenty-four hours, which abated somewhat on removing the tampon and dressing of the os; the nausea continued, however, for twenty-four hours longer. There was no other constitutional disturbance, no febrile excitement and no pain in the uterine region. Menstruation came on in five days after the operation, but the wound was found to be healed throughout its entire length.

Case V.—Mrs. L., aged 25, married seven years, sterile, had anteflexion from fibrous enlargement of the anterior wall of the uterus. The os was small, cervical canal contracted and cervix very large and hard. Dysmenorrhœa was a necessary consequence. Simpson's operation of incising the os and cervix was performed in October, 1860, and a small polypus was removed from the os internum. Great improvement resulted, but she still suffered at the menstrual period, and as the preceding cases had been so satisfactory, I determined to resort to amputation, although I had some misgivings about its propriety at this time, as she had a severe attack of metritis in December, 1860, excited probably by the use of a sponge tent. She insisted, however, on the operation, and it was performed on the 2d of July, 1861, Prof. Elliot, Dr. Woodhull, Dr. Emmet, and Dr. Pratt assisting. Duncan and Flockhart's chloroform was used. There was no nausea and no prostration, as in some of the preceding cases. I doubted for a while whether the excessive depression in these was due wholly to the anæsthetic or in some degree to the operation, but subsequent experience with chloroform, in numerous cases in Hospital and in private practice established the gratify-

ing fact that the impurity of the chloroform used was alone blamable. In this case, the cervix was very large and much longer than in any of the others, being one inch and a half from the os tincæ to the insertion of the vagina posteriorly, less anteriorly, as there was flexure. There was not a single untoward symptom after the operation. The silver sutures were removed on the eighth day, the parts having united perfectly.

Case VI.—Mrs. L., aged 32, married ten years, sterile, menses painful and scanty. Leucorrhœa for many years, now purulent and profuse, producing excoriation and soreness externally; sometimes bloody, sanious, fœtid, and attended with occasional lancinating pains. She has been confined to her bed for the last fifteen months. The cervix is large, very hard, fissured, of a reddish color, and covered with an abundant secretion of mucus and pus. She had received very judicious treatment from her family physician, Dr. Brown, of Hampton, N. J., who brought her to New York for consultation, when it was determined to amputate the cervix at once. The operation was performed, July 10, 1861, in the same manner as in the preceding cases, in the presence of Prof. A. K. Gardner, Dr. Worster, Dr. Marston and Dr. Brown. She recovered from the anæsthetic (chloroform,) without depression, is free from any constitutional disturbance, (pulse 60,) and twenty-four hours after the operation, appears to have the prospect of a rapid recovery.

Lisfranc first established Amputation of the Cervix Uteri as a standard operation, and it has been often performed since his day. But we are indebted to Huguier, of Paris, for giving it a larger range of application. I claim only to have made it simpler and safer.